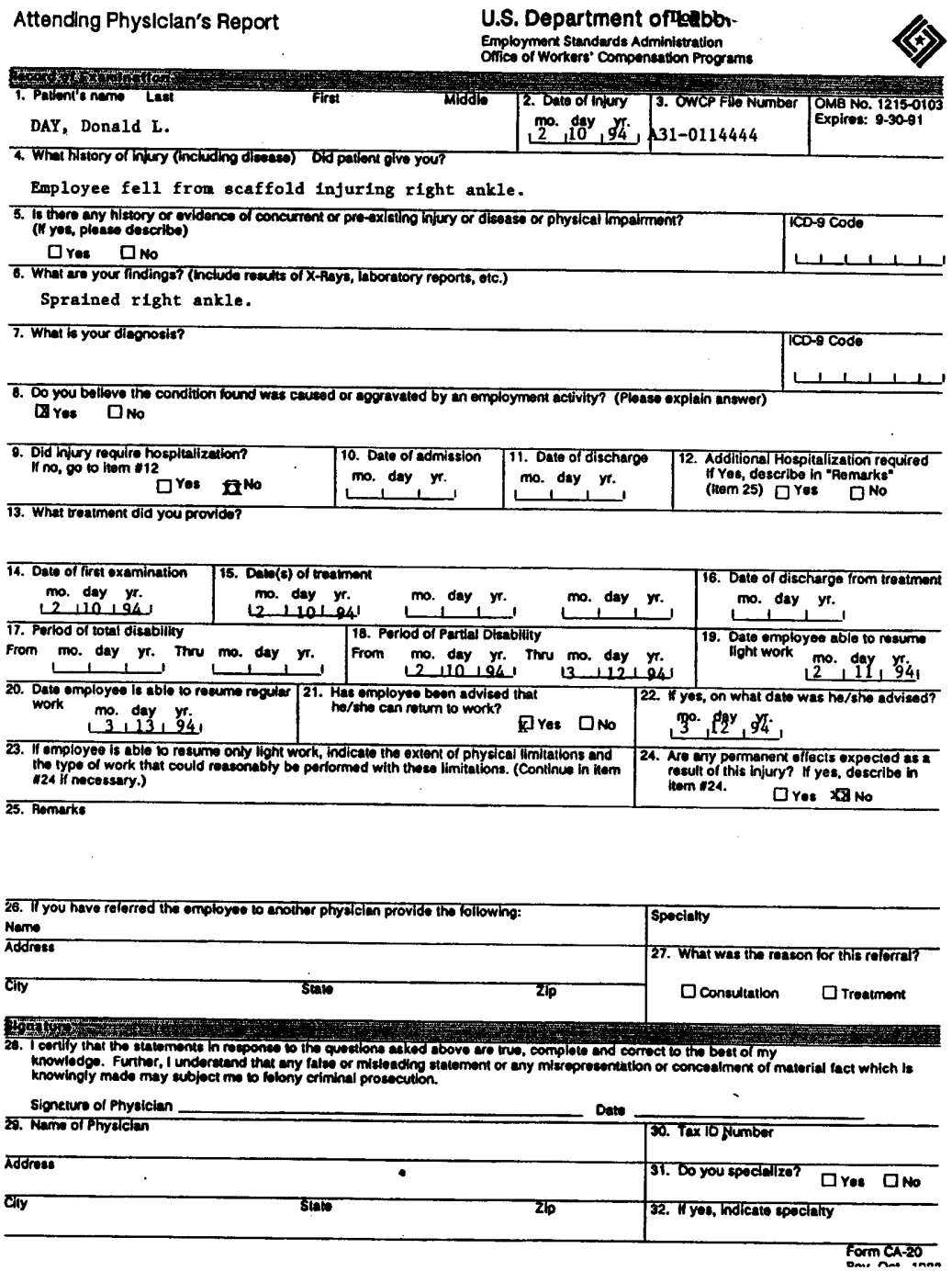
Figure SC810.F18. Form CA-20, "Attending Physician's Report"



Attending Physician's Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Physician's Section

1. Patient's name Last First Middle: DAY, Donald L.
2. Date of injury: mo. 2 day 10 yr. 94
3. OWCP File Number: A31-0114444
OMB No. 1215-0103 Expires: 9-30-91

4. What history of injury (including disease) Did patient give you?
Employee fell from scaffold injuring right ankle.

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No — ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)
Sprained right ankle.

7. What is your diagnosis? — ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) ☒ Yes ☐ No

9. Did injury require hospitalization? If no, go to item #12 ☐ Yes ☒ No
10. Date of admission: mo. day yr.
11. Date of discharge: mo. day yr.
12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination: mo. 2 day 10 yr. 94
15. Date(s) of treatment: mo. 2 day 10 yr. 94; mo. day yr.; mo. day yr.
16. Date of discharge from treatment: mo. day yr.

17. Period of total disability From mo. day yr. Thru mo. day yr.
18. Period of Partial Disability From mo. 2 day 10 yr. 94 Thru mo. 3 day 12 yr. 94
19. Date employee able to resume light work: mo. 2 day 11 yr. 94

20. Date employee is able to resume regular work: mo. 3 day 13 yr. 94
21. Has employee been advised that he/she can return to work? ☒ Yes ☐ No
22. If yes, on what date was he/she advised? mo. 3 day 12 yr. 94

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #24 if necessary.)
24. Are any permanent effects expected as a result of this injury? If yes, describe in item #24. ☐ Yes ☒ No

25. Remarks

26. If you have referred the employee to another physician provide the following:
Name
Address
City State Zip
Specialty
27. What was the reason for this referral? ☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date _____

29. Name of Physician
Address
City State Zip
30. Tax ID Number
31. Do you specialize? ☐ Yes ☐ No
32. If yes, indicate specialty

Form CA-20

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-31 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 16; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

EMPLOYEE (or person acting on the employee's behalf) - Complete items 1 through 19 and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete items 20 through 37 and promptly forward the form to OWCP.

ITEM EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Item Number	Explanation
4) Period of Wage Loss for which Compensation is Claimed	Enter inclusive dates covering the period for which you are claiming compensation. If intermittent periods are claimed, use a separate sheet to list each period individually.
5) Is This a Claim for a Schedule Award?	Schedule awards are paid for permanent impairment to a member or function of the body. A claim for a schedule award should not be made on the same form as a claim for compensation for wage loss; rather, a separate CA-7 should be used.
6) Has Any Pay Been Received for Period Shown in Item 4?	This question includes leave pay and COP received from the Federal job in which you were injured; and pay for work actually performed, whether at the Federal job in which you were injured or at other employment (including self-employment).
7) If Yes, Amount	Give the amount of pay received and the period for which it was paid. If there is more than one period, or more than one source of pay, explain fully on a separate sheet.
8) Was Claim Made Against 3rd Party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
13) List Your Dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
21) If Employee Received Additional Pay, Identify Type and Show Amount	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
28) Type and Inclusive Dates Employee Received Leave for Any Part of Period Since Stopping Work	Enter inclusive dates covering each period of leave. If leave was used for more than four individual periods, continue on a separate sheet. If leave was used for part of each day during a period, state how many hours were used per day; if the number of hours used per day varied, use a separate sheet to list each day.
29) Dates of Pay Continuation (COP) During Period of Disability	Enter the period of Continuation of Pay (see form CA-1 for a full explanation). If the injury was not a traumatic injury reported on form CA-1, this item does not apply.
30) Date All Pay Stopped	No compensation is payable for temporary total disability until the employee enters a non-pay status; therefore, item 30 refers to termination of all pay, including leave. Compensation is not payable for the first three days of disability after the end of any COP unless the disability exceeds 14 calendar days.

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment.

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.